UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

INSULIN PENS OR CARTRIDGES (Humalog / Novalog)

Patient name:_____Medicaid or SS# _____

Physician Name:_____Contact person:_____

Phone#:_____Ext. and options_____

Fax#_____Pharmacy_____

Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

_____

FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA

- Medicaid will only pay for the insulin cartridge or pen for those that are legally blind

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Telephone request from physician's office or pharmacy.